MANAGING EROTIC FEELINGS IN THE PHYSICIAN–PATIENT RELATIONSHIP

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Abstract • Résumé

In spite of prohibitions against the sexual involvement of physicians with their patients, erotic feelings sometimes arise in physician–patient relationships. The authors suggest that physicians can protect themselves and their patients from the harm that results from sexual involvement by establishing behavioural limits for their professional relationships, responding to patients' sexual overtures in a firm but nonjudgemental manner, examining their own sexual feelings rationally, seeking consultation if necessary and terminating the relationship if sexual feelings are compromising patient care. The challenge for physicians is to acknowledge that sexual feelings can arise and to manage such feelings for the sake of their own and their patients' well-being.

Même si les contacts sexuels entre médecins et patients sont interdits, les relations médecin–patient donnent parfois naissance à des sentiments d'érotisme. Les auteurs indiquent que les médecins peuvent protéger leurs patients et se protéger eux-mêmes contre les préjudices découlant de contacts sexuels en établissant des limites de comportement dans le cadre de leurs relations professionnelles, en répondant avec fermeté aux avances sexuelles de patients, sans toutefois les juger, en analysant rationnellement leurs propres sentiments sexuels, en consultant quelqu'un au besoin et en mettant fin à la relation si des sentiments sexuels mettent en danger le traitement du patient. Le défi pour les médecins consiste à reconnaître que des sentiments sexuels peuvent faire leur apparition et à les gérer en fonction du mieux-être de leurs patients et du leur.

Concern about physician–patient sexual relationships has recently skyrocketed, generating research, government inquiries and severe new penalties for professional misconduct.[1] Physicians are receiving a renewed strong message that sexual activity with a patient is unethical and damaging to both parties. What is being ignored in all this furore is that erotic feelings on the part of the physician, the patient or both will inevitably arise from time to time because of the private, warm, and often intense nature of the therapeutic relationship.[2–7] Physicians and most patients know that they should not act on such feelings. But what *should* physicians do when they become aware of their own or their patients' sexual feelings?

Although the prevalence of sexual contact between physicians and patients has been studied[3,5,7–13] researchers have used various definitions of sexual misconduct. With sexual intercourse as a conservative criterion for physician–patient sexual involvement, the estimated prevalence rate ranges from 0%[13] to 9%[3]; the rate may be declining, however, at least among psychotherapists.[14] Nevertheless, a number of physicians still engage in sexual activity with their patients, and those who are charged and disciplined probably represent a small minority of the offenders.[9]

Factors that increase a physician's risk for sexual involvement with a patient include being male and having female patients,[3] being considerably older than one's patients,[3,15] having a high level of educational and professional achievement,[3,16] using nonsexual touch more with patients of the opposite sex than with patients of the same sex,[17] having previously been involved sexually with a teacher or supervisor,[18] experiencing a life crisis,[19–21] engaging in substance abuse[21,22] and denying the negative effects of such involvement for the patient.[19–21,23] The most important risk factor, however, is probably previous sexual involvement with another patient.[24] Although a number of patient characteristics have been suggested as factors, none has been found to consistently increase the risk of involvement.[14]

Much of the research into the impact on the patient of sexual involvement with his or her physician has focused

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specifically on psychotherapeutic relationships. These studies have consistently found that sexual involvement negatively affects the well-being of the patient.[3,15,19,25–28] Pope[29] concluded from a literature review that the negative consequences of sexual involvement with a psychotherapist include feelings of ambivalence, guilt and emptiness, sexual confusion, reduced ability to trust, identity problems, emotional lability, rage, increased suicidal risk and cognitive symptoms of posttraumatic stress. Some studies have looked at the treatment of offenders and of sexually abused patients.[30,31] However, relatively little research has been done on prevention, including approaches to physician training or self-monitoring that would reduce a physician's likelihood of becoming a sexual offender. There is no published research on this topic, and the little theoretical writing that exists in this area[6,10,32–34] is often addressed to nonmedical practitioners or exclusively to psychotherapists.

This article is an attempt to remedy that deficit. We propose a series of behavioural and cognitive steps that physicians can take to reduce their risk of becoming sexually involved with a patient. These steps are based on our clinical and teaching experience; empirical findings are not yet available. We do not attempt a detailed discussion of sexual transference and countertransference, topics that have been examined by others.[10,35–39]

Before erotic feelings arise

It is important for physicians to set limits on their professional relationships before a crisis develops. Such limits might include the following.

- Never have sexual contact with patients (touching with the goal of sexual pleasure for oneself or the patient).
- Never date or flirt with patients.
- Avoid socializing with patients.
- Avoid nonclinical touching of patients.
- Never discuss one's personal sexual feelings and experiences with patients.
- Do not dress in a sexually provocative manner at work.
- When possible have support staff or the patient's relatives in the close vicinity when seeing a patient, and always when examining a patient's genitalia.

Obviously not all these rules are appropriate for every situation. Balint,[40] for example, describes how many patients think of their general practitioner as a family friend or distant relative. Nevertheless, physicians must establish professional boundaries and arrange their practices in a way that facilitates the maintenance of those boundaries.

The purpose of setting boundaries beforehand is to avoid the "slippery slope" of gradually increasing violations. Several authors have described behaviours that may lead physicians down the slippery slope.[22,41–44] Rutter[41] identifies such behaviours as fantasizing about patients, asking about a patient's sex life when this is not relevant to the presenting problem, closing the physical space between oneself and the patient to see how he or she reacts and arranging to meet the patient outside the office. By establishing limits physicians will be better able to identify boundary violations at an early stage, before more serious abuses occur. They will have a behavioural framework within which to ask themselves: I don't usually do this with patients. Why am I acting this way now?

When the patient expresses sexual feelings

Patients communicate sexual feelings for their physicians in many ways. Sexual interest may be expressed directly — for example, by describing erotic fantasies or making a sexual invitation. Two messages are crucial at this juncture. First, the patient needs to know that the physician accepts the patient's feelings and is comfortable discussing and trying to understand them. Patients are often extremely embarrassed about their feelings and are very vulnerable to rejection or negative judgement. They need a matter-of-fact, nonjudgemental, intellectually interested response to provide reassurance, build trust and foster self-esteem. The physician might say: "I am glad you told me about your feelings. Those things can be really hard to talk about. It's not unusual for patients to sometimes have such feelings for their physician."

Second, the physician should clearly explain that the limits of the relationship are secure and that there will be no acting out of the patient's sexual feelings. It should be made clear that this is because sexual involvement would destroy the effectiveness of the professional relationship, not because of marital status, lack of attraction or some other factor. If the physician is practising insight-oriented psychotherapy it is also important to explore the roots and meaning of the patient's behaviour and how these dynamics affect his or her other relationships. Otherwise, the physician may either avoid such exploration or refer the patient for psychotherapy.

The situation is more complicated when the patient communicates sexual feelings indirectly. Compliments on the physician's appearance, social invitations or questions about the physician's personal life may signal a sexual attraction. Nonverbal behaviour such as dressing or moving seductively may also indicate sexual interest. This kind of behaviour is more difficult to deal with because the physician may fear that he or she is reading more into the situation than the patient intends.

Whether the physician should make explicit the sexual message that he or she detects depends on the nature of the therapeutic relationship. The more the relationship tends toward psychotherapy, especially insight-oriented psychotherapy, the more the physician should clarify and interpret the patient's message. If the relationship is new or fairly superficial the physician should ignore an indirect sexual message or respond only briefly. The physician might increase the formality of his or her behaviour without directly commenting on the patient's subtle or not-so-subtle message.

The physician has the right and the responsibility to protect himself or herself from aggressive sexual overtures, sexual harassment and assault. In such extreme cases the physician's safety becomes the primary concern, and usually the relationship should be terminated.

When the physician experiences sexual feelings

The following are some examples of early signs that the boundaries of the physician–patient relationship are in danger of being transgressed.

- Dr. X is having difficulty concentrating on what his attractive new patient is saying as he is increasingly aware of her beauty and of his own emotional and physical reaction to her. When she leaves the office he feels confused but happy, and he books a follow-up appointment for only a few days hence.
- As Dr. Y is listening to her patient describe his energetic and creative sexual relationship with his girlfriend, she becomes physically aroused and begins to fantasize about engaging in sexual activity with him.
- Dr. Z is providing psychotherapy for a patient who is in a lonely and unsatisfying marriage. He likes and admires her and occasionally thinks that she would be much happier married to him.

Such experiences are common. They can affect well-trained, highly effective professionals and do not in themselves indicate psychologic problems or inappropriate behaviour. Furthermore, they are not harmful to the physician or the patient provided that the physician manages them suitably. They are, however, important signals that need to be attended to so that the therapeutic value of the relationship is not undermined.

The first step for the physician is to bring his or her feelings into conscious awareness and to clarify them. Sexual feelings are much more likely to wreak havoc when they are unacknowledged, then expressed indirectly and, eventually, acted out. The physician needs to ask:

- What am I feeling about this patient?
- What is triggering these feelings? Some characteristic of the patient? Some issue affecting my own life? An interaction of the two?
- Are these feelings interfering with my ability to listen to my patient and to focus on his or her needs rather than on my own?
- How can I use my feelings to help me understand my patient and myself better?

Sometimes sexual feelings about a patient fade away quickly without intervention. If they persist, however, the physician must carefully adhere to his or her preestablished professional limits and perhaps increase them as extra insurance (e.g., by arranging for another physician to examine the genitalia of a patient for whom he or she has erotic feelings). Although increasing the professional distance in the relationship may damage the intimacy between physician and patient, this is clearly preferable to a violation of boundaries. The physician's ability to offer a warm, caring, nonsexual relationship is absolutely crucial to a patient's well-being, and the physician's formality can be very reassuring.

The physician's next challenge is to come to terms with the erotic feelings so that he or she can continue to provide good treatment. Cognitive techniques can be used to identify and modify the thoughts that underlie such feelings. For example, Dr. Z might consider whether by marrying him the patient would really improve her situation — whether the process of divorcing her husband, ending her therapeutic relationship with Dr. Z and establishing a personal relationship with him (and discovering those shortcomings that were not evident when he was in his professional role) would really improve the quality of her life. Sexual feelings and fantasies are often based on irrational thoughts that can be identified, challenged and thereby diminished.[45]

Some "working-through" techniques may not be appropriate. For example, deliberately fantasizing about a patient may increase one's likelihood of acting on sexual feelings. It is the physician's job to understand and control his or her sexual feelings, not to indulge them. It is also inappropriate for the physician to discuss his or her sexual feelings with the patient. These feelings are the physician's concern and do not belong in the patient's session. Disclosure is especially inadvisable when the physician may subsequently be required to examine the patient's genitalia. This situation is so dangerous that disclosure of sexual feelings for a patient and genital examination of the same patient should be considered mutually exclusive.

This is not to say that a physician should never discuss a patient's sexuality or sexual attractiveness, but that such discussion should be general rather than personal. However, if the physician is not sure that a remark on the patient's sexual attractiveness is suitable, it is generally better to err on the side of caution and refrain from making the comment.

In spite of a physician's efforts to manage, analyse and

challenge sexual feelings for a patient, these feelings can persist or even grow. At this point the physician must seek help. Early consultation may resolve the problem easily and quickly, but physicians who work in professional isolation may find a consulting relationship more difficult to initiate. Physicians value their professional independence and may find it humiliating to seek help, especially with regard to feelings as personal and threatening as sexual attraction for a patient. However, physicians who are committed to providing the best possible care for their patients will recognize the necessity of getting help. The essential elements of such consultation are confidentiality, trust in the consultant and the goal of assisting the physician to maintain professional behaviour while increasing self-understanding and skill in relating to patients.

If all else fails, the physician must refer the patient to another professional. The physician must explain to the patient that because of personal problems he or she will no longer be able to provide treatment but will help the patient to find another physician. The physician should not indicate the specific nature of the problem but should emphasize that the difficulty is the physician's, not the patient's. If referral to another physician is not possible, then the physician must continue to maintain his or her behavioural controls and to attempt to come to terms with the sexual feelings.

The question of whether or when it is appropriate for a physician to enter into a sexual relationship with a former patient is controversial.[5,10,12,38,46–51] Ethical standards proposed or adopted recently by several professional organizations[1,52] make it clear that termination of the therapeutic relationship should not be viewed as a stepping-stone to a sexual relationship. The most prudent policy is to regard all patients, especially psychotherapy patients, as permanently off limits as sexual partners.

The management of erotic feelings in the therapeutic relationship is a challenging part of being a physician. At times the physician may feel that his or her predicament is ridiculous, frustrating or even tragic. But these crises provide an important opportunity for professional and personal growth. The choice is between using patients to meet personal needs in an ultimately destructive way and honouring one's commitment to give every patient the best possible care.

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